TUBERCULOSIS SUSPECT CASE REPORT

Nsg Station/Ph# _____
Pt. Room# _____
C.M. Name _____
Ph# _____

PATIENT: _____
Last First MI
ADDRESS: _____

Phone: (____) Cell:(____)
BIRTH DATE: ____/____/____ SEX ☐ M ☐ F
SSN# ____/____/____
EMPLOYER/SCHOOL: _____
Phone: (____)
EMERGENCY CONTACT: _____
<18 y/o, parent's name/DOB _____
INSURANCE/FUNDING: _____
☐ White, non-Hispanic ☐ Black ☐ AM Ind/Eskimo
☐ Hispanic ☐ Asian/Pac. Is. (specify)_____
☐ Other_____

REPORTED BY: _____
PHONE: (____) _____
DIAGNOSING FACILITY: _____

MEDICAL RECORD# _____
Patient hospitalized at diagnosis? ☐ Yes ☐ No
Patient currently hospitalized: ☐ Yes ☐ No
Paramedics notified? ☐ Yes ☐ No ☐ N/A
☐ PHYSICIAN: _____

Phone: (____)
☐ PHYSICIAN: _____

Phone: (____)

☐ Pulmonary ☐ Extrapulmonary (site)_____ Date dx: ____/____/____
Skin Test_____mm ☐ Negative Chest X-Ray Date:_____ ☐ Cavitary ☐ Non-Cav.
Date read_____ ☐ Not done Impression: _____
Quantiferon result: neg pos Date:_____

If Pulmonary, check symptoms:

☐ Cough; Start Date _____ ☐ Night sweats/Fever
☐ Sputum production ☐ Hemoptysis
☐ Weight loss (# of lbs.)_____(# of mos.)_____ ☐ Fatigue

History of TB Treatment ☐ Yes ☐ No ☐ LTBI
If Yes: Where/when treated?_____

If asx, reason for evaluation:_____
Other medical conditions relevant to diagnosis:_____

Date/HIV: ☐ Positive ☐ Negative
_____ ☐ Recommended
Patient's current weight_____lbs_____kg
Psychosocial History?_____

Date/CD4 ____/____ Date/VL ____/____ Allergies_____

SPEC. #	SPEC. DATE	SPEC. TYPE	AFB SMR.	MTD/PCR	AFB CULT

MEDICATIONS	DOSE	START DATE
ISONIAZID		
RIFAMPIN/RBN		
ETHAMBUTOL		
PYRAZINAMIDE		
PYRIDOXINE (B6)		

LAB NAME: _____ HAART _____
PATH REPORT: _____ DOT ☐ Yes ☐ No If no, call TBC

ADDITIONAL COMMENTS: _____

DATE REPORTED:_____ INTAKE STAFF:_____(____)

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NICK MACCHIONE, FACHE
DIRECTOR

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PUBLIC HEALTH OFFICER

County of San Diego
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PUBLIC HEALTH SERVICES
TUBERCULOSIS CONTROL BRANCH
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Community Epidemiology
Emergency Medical Services
HIV/STD Hepatitis
Immunization
Maternal, Child and Family Health
Services Public Health Laboratory
Public Health Nursing/Border Health
TB Control & Refugee Health
Vital Records

TUBERCULOSIS CONTROL

Reporting of all patients with confirmed or suspect tuberculosis (TB) is mandated by state Health and Safety Codes Div. 4, Chapter 5 and Admin, Codes, Title 17, Chapter 4, Section 2500 and must be done within **one day of diagnosis**.

WHY DO YOU REPORT?

Because it is the law! The health department performs many vital functions to ensure public health and safety, including case management, contact follow-up, assessment of compliance with treatment and appointments, and directly observed therapy (DOT). The TB Control staff will also assist in facilitating timely and appropriate discharge planning. **Since January 1, 1994, state law mandates that all TB patients have a health department-approved discharge plan, *prior* to discharge**.

WHO MUST REPORT?

Anyone aware of a patient suspected to have, or confirmed with, active TB.

WHEN DO YOU REPORT?

A) When active TB is one of the primary differential diagnoses. This often occurs when:
   1. signs and symptoms of TB are present, and/or
   2. the patient has an abnormal chest x-ray consistent with TB, and/or
   3. the patient is placed on multidrug therapy for active TB or

B) When specimen smears are positive for acid fast bacilli (AFB).

C) When the patient has a positive *M. tuberculosis* or *M. bovis* culture.

HOW DO YOU REPORT?

The form on the other side is to be completed **in its entirety** and submitted to the health department. TB Control staff will review this form and may return a call to the physician as needed.

By phone: (619) 692-8610

By pager: (877) 401-5701 (weekdays 8:00 a.m.-5:00 p.m., weekends/holidays 8:00 a.m.-5:00 p.m.)

By FAX: (619) 692-5516

This form, when submitted to TB Control, fulfills the legal requirement for reporting. The process for discharge or transfer approval necessitates a different form. Please call (619) 692-8610 for further information about discharge care plan submission/approval.